Meeting Summary
Rural Health Care Delivery Workgroup: Workforce Development

October 21, 2016
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Advisory Group Member Attendees:

Kevin Beverly
Richard Colgan, M.D.
Senator Adelaide Eckardt
Wayne Howard (advisory group leader)
Lucie Hughes
Doris Mason
Gene Ransom
Freida Wadley
Adam Weinstein, M.D.

Other Attendees:
Joe Ciotola, M.D. (work group chair)
William Huffner, M.D.
Temi Oshiyoye
Commissioner Stephen Thomas

Commission Staff Attendees:

Erin Dorrien
Kathy Ruben
Ben Steffen

Welcome and Introductions

The meeting convened at approximately 3:15pm. Wayne Howard, who is the advisory group leader and former CEO of the Choptank Health System, introduced himself, and welcomed everyone. Mr. Howard said he is looking forward to working with the Advisory Group examining what is happening in the five counties on the Mid-Eastern Shore in terms of strategies to expand the health care workforce. Mr. Howard then asked for a roll call of Advisory Group attendees and went over the agenda for the meeting. He suggested that the group go over each of the five discussion questions that were formulated for the group, as well as any other issues that the group deems necessary.

Guided Discussion

The following discussion questions were given to the advisory group as the basis for their discussion:

1) In terms of health care delivery, what are the greatest areas of workforce shortages in the rural Maryland/five jurisdictions of interest?
2) In terms of current programs, what is working and what is not working? How is "success" or "what is working" determined or evaluated?
3) What are the essential components to creating, implementing and sustaining successful workforce programs in rural areas? Are there current models that could be explored/replicated?
4) How can innovative programs that work to recruit or retain providers be sustained?
5) Are there specific regulatory barriers to maintaining an adequate workforce in rural areas?

Question 1

Mr. Howard led the discussion for the first question. He noted that in terms of workforce shortages, the Mid-Eastern Shore is in need of primary care providers. Rural areas also need good suggestions for recruiting and retaining these providers. Kevin Beverly, the President of Social & Scientific Systems, stated that there must be some data that will give the group an answer to the first question, perhaps through a survey. Senator Adelaide Eckardt told the group that several years ago the Maryland Hospital Association conducted a primary care shortage survey. William Huffner, MD the Chief Medical Officer and Senior Vice President, Medical Affairs at UM Shore Regional Health said the assessment was completed about five years ago. He noted that primary care was a significant problem at that time.

Dr. Huffner also told the group that UM Shore Regional Health has just completed an RFP with an external consultant to examine the current state of the workforce. Not only will the consultant look at primary care providers, but they will also look at other health care professionals, including nurse practitioners and physicians' assistants. Dr. Huffner stated that the study will help UM Shore Regional Health address population health care needs. They will take actions based on the findings; taking population demographics such as diversity and aging into consideration.

Dr. Joseph Ciotola, the Health Officer and EMS Director for Queen Anne's County, noted that the current study by the University of Maryland School of Public Health may provide additional information about advanced practitioners in the five county Mid-Shore region. Dr. Freida Wadley, the CEO of Quality Health Strategies, noted that we need information about dental professionals and nurses. Doris Mason, of the Rural Maryland Health Association, added physical therapists and occupational therapists to the list of health care practitioners for which the work group needs more information. Senator Eckardt reminded the group that mental health

professionals are part of the puzzle. Mr. Howard agreed that the work group wants to expand its knowledge way beyond primary care.

Commissioner Stephen Thomas described a similar study that was completed by the University of Maryland School of Public Health in Prince George's County, Maryland. That Public Health Impact Study had built upon existing relevant reports and studies and also provided new data. He said that he had recently spoken with Dr. Dushanka Kleinman, the Associate Dean for Research and a Professor within the Department of Epidemiology and Biostatistics in the University of Maryland School of Public Health who told him the School of Public Health is currently updating existing data for use in the study. Senator Eckardt noted that the collection of new data takes a long time. Mr. Howard agreed and asked the advisory group about other sources of existing data. He noted that the Public Health Service used to provide this type of data and the Rural Health Association has similar data. Mr. Howard said that the Advisory Committee has to gather data together and map it out.

Dr. Adam Weinstein, with UM Shore Regional Health and also a Commissioner, reminded the Advisory Group that the Workgroup has to look beyond just defining the problem. They have to think broadly about structural changes that must be made. He noted the type of specialists that are needed in the Mid-Shore region, such as cardiologists and pulmonologists, and the difficulty recruiting these specialists. Mr. Howard stated that we need to know the types of health care professionals that are needed to develop the right model. He gave the example of a private-public partnership. Mr. Beverly noted that in order to develop the right model or to build a new system of care, the group must know more about the population characteristics and concerns of the residents. For example, he said, cancer is of great concern to the residents and the cancer rate is much greater on the Eastern Shore than the national average. Dr. Ciotola suggested that the group request data at the next work group meeting. He said that the group needs to make a list of the data that is needed and the types of providers that are needed in the area.

Question 2

Mr. Gene Ransom, CEO of MedChi, began the next topic by discussing what approaches in the area are not working to increase the workforce. He noted that you can't have one hospital "poaching" doctors from another hospital. Mr. Howard agreed with Mr. Ransom's comment and said there should be collaboration. One Advisory Group member asked the question "if we are going to subsidize health care professionals, where is the money going to come from?"

Mr. Ransom then discussed some of the problems with three programs; the Loan Repayment Program, the J-1 Visa Waiver Program, and the Tax Credit Program. He told the group that the federal funds in the Loan Repayment Program are not getting used since they are only for non-profit use. He noted that the tax situation with this program can also be problematic for the doctors, so perhaps the tax laws must be changed. Mr. Ransom then described the

application process for the J-1 Visa Program which is not an easy process and has a long waiting time. He thanked Senator Eckardt for her help with several applications. Finally, Mr. Ransom noted that there are many stipulations attached to the complicated Tax Credit Program. He said that it should be made easier to apply. Senator Eckardt agreed with Mr. Ransom's comment.

Temi Oshiyoye, from the DHMH Office of Population Health Improvement said that there are a lot of misconceptions about the Loan Repayment Program because it is actually two programs. The process for obtaining federal money for loan repayment is very strict. However, the State is very flexible. Ms. Oshiyoye stated that one of the only reasons that an individual would not qualify is if they were only working part-time. The Program, which used to offer primary care physicians and specialists educational loan repayment in return for work in a Health Professional Shortage Area (HPSA), is now open to other types of providers such as Physician Assistants.

Ms. Oshiyoye said her department is open to suggestions on how to improve the program. She noted some of the changes that were made to make the Program more flexible and to motivate physicians to use the Program. The amount of the loan repayment was increased from $25,000 to $50,000 and some of the guidelines were changed. She said it took a year to be able to make these changes. Mr. Ransom commented that perhaps some of the statutes could be changed.

Medical School Programs

Dr. Richard Colgan, from the University of Maryland School of Medicine brought up the topic of medical school programs. He noted that Maryland is 50th in the country for the number of medical students in Maryland schools that go on to practice in primary care. Many residents do a sub-specialty. He suggested that perhaps the schools should be monitored to see who goes into primary care. Dr. Colgan how we can get these physicians to practice in rural areas. Mr. Steffen noted that Johns Hopkins doesn't have a family medicine program, which may contribute to the poor statistics of the number of Maryland medical students going into primary care. He said we have to look for models to establish practices in rural areas.

Question 3

In looking at various models for getting physicians to practice in rural areas, Mr. Steffen brought up the example of Shah Associates in Southern Maryland. This practice has grown to more than 100 physicians. He noted that if there is a one to two physician practice that is not making enough revenue, it will be difficult to bring in a new physician. Mr. Howard suggested a mandate of how many graduates actually go into primary care. He then brought up the example of the Eastern Virginia Medical School which was created by the State to create primary care

physicians. Another Advisory Group member suggested a medical school on the Eastern Shore. Dr Colgan said that idea has limitations, including the need for OB training. The group then briefly discussed Med Star St. Mary's rural residency program. Senator Eckardt mentioned that this was just a track. There are many issues to be considered when designing a rural residency program, however, it was suggested that this may be the direction that Maryland needs to go.

Mr. Steffen suggested the application of the Robert Graham Center Medical School Mapper which is a free, online data visualization tool that highlights where graduates of medical schools are practicing as well as how reliant communities are on graduates from that state or program. Mr. Steffen said that this information can be made available to the Advisory Group. It was noted that Johns Hopkins residents do not always stay in Maryland, but University of Maryland students are much better in that respect.

Question 4

A brief conversation ensued about the economic sustainability of medical practices and programs on the Eastern Shore. Mr. Howard noted that any model that the advisory group develops must be balanced. It is best to attract and train practitioners locally so they can get to know the community. Senator Eckardt described recruitment of students with the right incentives and grooming a career around the practice. Dr. Weinstein mentioned no-interest loans and low interest small-business loans. The group discussed the difficulty of taking out loans to start a practice, including putting family assets at risk. Medical practices are no longer considered an asset unless there are tangible assets.

Due to the time, Erin Dorrien, the MHCC Chief, of Government & Public Affairs introduced the speaker for the afternoon; Temi Oshiyoye, from the DHMH Office of Population Health Improvement. Mr. Ransom suggested that the Advisory Group members write up statements concerning the workforce issues. Ms. Dorrien said she would then aggregate the issues and questions.

Presentation by the State Office of Rural Health and Workforce Development

Temi Oshiyoye provided a presentation for the Advisory Committee entitled *The State Office of Rural Health and Workforce Development Recruitment Efforts*. She began the presentation with an overview of this State Office's current workforce development programs, including 3Rnet, the Tax Credit Preceptor Program, Area Health Education, J1 Waiver, National Health Service Corps (NHSC), the State Loan Repayment Program (SLRP), and the Maryland State Loan Repayment Program (MLRP). The objective of these programs is to aid with the recruitment and retention of the health care workforce. Ms. Oshiyoye noted that the group has already covered some aspects of these programs. Ms. Oshiyoye described the role of the

Maryland State Office of Rural Health in providing technical assistance to rural entities, collecting and disseminating information, and developing partnerships to support efforts to recruit and retain health care providers in rural areas.

Ms. Oshiyoye provided several definitions for the Advisory Group, including that of: Health Professional Shortage areas (HPSA), Medical Underserved areas (MUA) and Primary Care Providers; to clarify differences in federal and state definitions. She provided a graphic representation of the Federal and State Designated Rural areas in Maryland and noted the differences between the two, as well as a chart of the current health care workforce in the five county region in terms of primary care providers, dentists, professional counselors, social workers, psychiatrists, and psychologists. Senator Adelaide Eckardt asked if the same information was available for nurses. Ms. Oshiyoye replied that the information she presented came from the Board of Physicians and that the same information on nurses could be obtained from the Board of Nurses. Ms. Oshiyoye then described each of the workforce development programs in greater detail.

3RNET

The National Rural Recruitment & Retention Network is a nonprofit organization focused on jobs specifically geared to candidates interested in rural and underserved areas in America. Ms. Oshiyoye described it as a "website for Rural America" that is "better than a recruiter for looking for a physician". Between 10/01/2015 and 09/30/2016, there were 639 active candidates interested in working in Maryland. Each provider on the website is in a rural county. In Maryland, there are 62 registered facilities. Job listings contain information for the candidates on what is available (such as loan repayment) and what they need (such as a visa).

Tax Credit Preceptor Program

The next program discussed by Ms. Oshiyoye was the Tax Credit Preceptor Program from Senate Bill 411. This is a new program that gives a credit against State income tax for those who preceptor certain programs and who work in certain areas of the State with health care workforce shortages. She then described these shortage areas such as HPSAs, MUAs, and MUPs. Mr. Beverly asked if there were any mechanisms for encouraging physicians from other areas such as Montgomery County to go to rural areas to preceptor. Senator Eckardt said that it was not just the delivery of care in these areas, but the preceptor job that is eligible for the tax credit. She noted that this has been done in nursing. Mr. Steffen asked about the number of participants needed to receive the tax credit. Ms. Oshiyoye replied that the requirement was a minimum of three and a maximum of ten students for 160 hours to receive $1,000/student credit.

Area Health Education Centers (AHECs)

The next discussion centered around Area Health Education Centers (AHECs) that work to improve population health through the recruitment, training and retention of diverse health care professionals in rural and underserved communities. There are three AHECs in Maryland. The thought was that individuals would end up practicing where they did their AHEC rotation. Ms.

Oshiyoye shared with the Advisory Group a study by the Maryland AHEC office, in collaboration with the University School of Medicine, from the class of 2008-2012. The study found a low retention of residents in rural counties and few practicing primary care. Individuals leave after their rotation is complete.

J-1 Visa Waiver Program

This Program is aimed at recruiting foreign-born primary care physicians requesting waivers for their J-1 Visa. The waiver is granted in exchange for the physician's agreement to work in an underserved area for three years. Ms. Oshiyoye explained the program's 30 waiver slots per federal fiscal year for primary care and specialty physicians. Twenty slots are for physicians in federally designated shortage areas and the other ten are FLEX spots that still are directed at serving underserved populations. Mr. Ransom remarked that it would be great to streamline this program or grant early entry for primary care physicians. Mr. Beverly asked if Americans trained in European or Caribbean medical schools are eligible for this program. Ms. Oshiyoye replied "no, only foreign-born students". Mr. Ransom commented on the lack of residencies for all who graduate from medical school.

National Health Service Corps (NHSC)

Ms. Oshiyoye then described the National Health Service Corps (NHSC) to the group. She said that this program is similar to the State Loan Payment Program, except practitioners apply directly to the federal government. Practitioners include primary care physicians, dentists, nurses, PAs, psychologists, therapists and social workers. Employees are reimbursed according to HPSA scores.

State and Maryland Loan Repayment Programs

Finally, Ms. Oshiyoye described the State Loan Repayment Program which is a federal program and the Maryland State Loan Repayment Program which is a collaborative effort between Maryland and the federal government. She told the group about the requirements for practitioners and their obligations, as well as the eligible practice sites. Many practitioners leave their site when their obligation is complete. Ms. Oshiyoye reminded the Advisory Group that the community has an obligation to make physicians feel welcome if they want them to stay. This may include strengthening their ties to the community. Mr. Steffen asked if the funds that are left over from this program are left for the program or if they go back to the federal government. Ms. Oshiyoye replied that the funds go back to the federal government.

Wrap Up and Next Steps

Erin Dorrien, the MHCC Chief of Government & Public Affairs thanked the entire advisory group for a productive session and described some of the next steps for the advisory group and for the Workgroup in general. She noted that the MHCC would look into providing data to the advisory groups. The next Workgroup meeting will be held November 1st in Cambridge, Maryland. Some of the ideas generated during this advisory meeting may be expanded on in future meetings. Advisory group members will be contacted by email about the next meeting. The meeting adjourned at approximately 5:20 pm.